WORLD HEALTH ORGANIZATION

TOBACCO ALERT

APRIL 1995

EDITORIAL

GLOBAL EPIDEMIOLOGICAL SURVEILLANCE OF THE TOBACCO PANDEMIC

One of the main WHO areas of action in the field of tobacco or health is the collection, validation and dissemination of technical data in support of national and international programmes and for global monitoring of aspects of tobacco production and consumption, national and international tobacco or health activities, and trends of diseases associated with tobacco use.

The need for WHO's Tobacco or Health programme (TOH) to establish and routinely update a comprehensive database on tobacco use and its consequences has been increasingly recognized and emphasized in recent years. WHO has been encouraging the development of better country-specific data, especially mortality and tobacco-use prevalence data, needed for the estimation of smoking attributable mortality; collecting certain key information on country-specific tobacco statistics; and promoting the funding and execution of longitudinal studies on tobacco use and mortality in developing countries.

Epidemiological surveillance is a reasonably self-contained and unquestionably important component of any assessment of the tobacco or health situation. Adequate epidemiological surveillance of the tobacco pandemic must recognize three broad and interrelated spheres which collectively define data collection and analytical strategies for monitoring the pandemic. In very broad terms, these are: ***exposure*** (prevalence, consumption, intensity, e.g. duration of smoking, degree of inhalation, tar/nicotine content, etc.); ***controlled epidemiological studies*** of smokers versus non-smokers to ascertain excess risk of death among smokers and how it changes over time; ***levels and trends*** in mortality and, where available, morbidity from diseases related to tobacco use (cancer, ischaemic heart disease, chronic bronchitis and emphysema).

WHO has established a TOH data centre which has established mechanisms for data collection, validation and maintenance (i.e. updating), computerization of data, and compilation of country profiles/regional analyses[1]. The first stage in the creation of the data centre was the establishment of individual country profiles. For each WHO region, the set of country profiles will be accompanied by a regional overview/synthesis.

The profiles are intended to provide a baseline situation assessment around 1990 (or the latest date for which data are available to WHO). However, important gaps remain to be filled for many countries and for some, very little information could be found. The profiles in their present state thus represent a first attempt to describe the tobacco or health situation. It is intended that they be updated, corrected and continuously reviewed as new data and information become available to WHO.

As a result of the work being developed by WHO a report of the global "tobacco or health" situation, including worldwide tobacco consumption, national tobacco consumption statistics, tobacco-related morbidity and mortality, national anti-tobacco legislation, and information on national, regional and international tobacco control programmes and their organization, is under preparation and will be published this year (***Tobacco or Health Situation Atlas [TOH Atlas]***, with detailed country profiles, graphs, maps, and analyses). The regular monitoring reports will be the main means of dissemination of tobacco or health information by WHO.

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[1] A preview of two country profiles are included in this issue of Tobacco Alert.

WORLD NO-TOBACCO DAY

The theme for World No-Tobacco Day, 31 May 1995, is:

"Tobacco costs more than you think"

The main celebration for World No-Tobacco Day will take place this year in Vancouver, Canada. The WHO launch of this special day will be held the morning of 31 May in a plenary session of Child Health 2000 at the 2nd World Congress and Exposition on Child Health. Dr H. Nakajima, Director-General, WHO, will give the keynote address and present Tobacco or Health awards to four medalists.

Tobacco costs more than you think

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WHO COLLABORATING CENTRES

A WHO Collaborating Centre forms part of an inter-institutional collaborative network set up by WHO in support of its programme at the country, intercountry, interregional and global levels, as appropriate. In line with the present WHO policy and strategy of technical cooperation, a WHO Collaborating Centre must also participate in the strengthening of country resources, in terms of information, services, research and training, in support of national health development.

Institutions showing a growing capacity to fulfil a function or functions related to the Organization's programme, as well as institutions of high scientific and technical standing having attained international recognition, may qualify for designation as a WHO Collaborating Centre.

Collaborating Centres are increasingly considered as an optimal way of promoting research and related activities within Member States.

BEIJING RESPIRATORY DISEASE RESEARCH CENTRE A WHO COLLABORATING CENTRE

One of WHO's Collaborating Centres on tobacco or health issues is the Beijing Respiratory Disease Research Centre. At the outset in 1986, the Beijing Heart, Lung and Blood Vessel Medical Centre was designated as a WHO Collaborating Centre. However, in 1989 the Collaborating Centre was moved to Beijing Respiratory Disease Research Centre, Beijing Red Cross Chaoyang Hospital. The Centre was first redesignated in 1990, and most recently in November 1994.

The Director of the Centre is Professor Weng Xinzhi, who is also a member of the WHO Expert Advisory Panel on Tobacco or Health since 1979. He has participated in most of the regional and international anti-tobacco conferences.

In its collaboration with WHO the Centre carries out the following activities:

- organizing and carrying out smoking surveys and anti-smoking education campaigns in the Beijing area, and making the results available to WHO;
- collaborating with institutions in other parts of China in organizing smoking surveys and anti-smoking education campaigns, and making the results available to WHO;
- carrying out research on the harmful effects of smoking in consultation with WHO;
- acting as a clearing-house for dissemination of information on tobacco or health activities within China.

There are three sections in the Beijing Respiratory Disease Research Centre, namely, the department of respiratory medicine, basic research laboratory and epidemiologic department, with the number of staff amounting to 70.

During the first period of designation, 1986–1990, the Centre, among other things, carried out a nationwide sampling survey of smoking prevalence of the general population at the age of 15 and above. This data was accepted as standard Chinese smoking prevalence. During the second period of designation, 1990–1994, a sampling survey of medical students, teachers and personnel was conducted by the centre. Studies on the relationship between smoking

Research laboratory, Beijing, China

and a number of coronary and respiratory diseases, as well as on other health hazards of tobacco smoking were also accomplished. Furthermore, the Centre has organized people in Beijing to celebrate the World No-Tobacco Day every year and has distributed millions of anti-smoking pamphlets to the public. Since 1989, the Centre has published "The Tobacco Control Newsletter" quarterly in Chinese and in English, which has been widely distributed to domestic and international anti-tobacco organizations.

Director of the Beijing Collaborating Centre, Professor Weng Xingfu

The Centre will continue to actively carry out national and international anti-tobacco activities. In addition, the Tenth World Conference on Tobacco or Health will be held in China in 1997, and naturally the Centre will support the Chinese Association on Smoking and Health (CASH) in the preparations for this Conference.

CHINA

China is the country with the world's highest cigarette production, as well as consumption, and the amount of cigarettes consumed has increased dramatically during the last decade. A national survey conducted in 1984 revealed that nearly 34% of adults are smokers, and among Chinese males over the age of 20 nearly three-quarters smoke. The morbidity and mortality rates of lung cancer, heart and chronic respiratory disease are increasing. It has been estimated that half a million Chinese are already dying each year through tobacco-induced diseases. If these trends continue, it is predicted that 2 million Chinese will die annually from tobacco-related disease by the year 2025. Considering this imminent situation it is of highest importance to urgently take all possible measures to prevent and reduce tobacco smoking in China.

WHO is one of the international agencies working to assist China, as well as other Member States, in their efforts to strengthen tobacco control policies and programmes. Essential for this work is the WHO network of collaborating centres on tobacco or health issues.

WHO COLLABORATING CENTRE OFFICE ON SMOKING AND HEALTH, USA

The Office on Smoking and Health (OSH), as the lead federal agency for tobacco control, serves as the focal point for all smoking and health activities in the United States. In this capacity, OSH's mission is to lead and coordinate strategic efforts aimed at the prevention and cessation of tobacco use and the protection of non-smokers. This mission is accomplished through on-going efforts to expand the science base of tobacco control, communicate information to constituents and the public, facilitate concerted action with and among partners, and build the capacity of our partners to conduct tobacco control programmes. Specific activities in support of these efforts include technical assistance to other US agencies, state health departments, and public health professionals; on-going surveillance and analysis of tobacco use and its impact, adding to the scientific base for assessing the health effects of tobacco use; the production of the Surgeon General's reports on the health consequences of tobacco use; and the use of highly successful public information and education programmes targeted to traditional constituents as well as specific at-risk populations including youth and minorities.

OSH continues to expand its growing network of tobacco control constituents throughout the United States and the world. This network includes public health professionals, scientists, and medical professionals, as well as state and voluntary/non-profit health organizations. Specific relationships currently exist with organizations such as the American Cancer Society,

American Medical Association, US Food and Drug Administration, National Medical Association, Robert Wood Johnson Foundation, Office of the US Trade Representative, and the World Health Organization.

Current Activities with WHO

OSH, through an umbrella cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), provides WHO's Tobacco or Health Programme (TOH) and Division of Health Promotion, Education and Communication (HPR) with financial support for health education efforts related to tobacco cessation programmes, efforts to control and prevent tobacco-related illnesses, and epidemiologic research. Specific activities in the fiscal year 1994 included the establishment of tobacco use prevention as one of the five major determinants for *Healthy Project 2020*, the preparation and implementation of Regional Action Plans, the provision of on-site technical assistance in up to five Member States in support of the development of tobacco control policies and programmes, and increased WHO participation in the Ninth World Conference on Tobacco and Health.

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WHO programmes responsible for the implementation of these activities are the Health Education and Health Promotion Unit, and Tobacco or Health. The primary OSH contact for this agreement is Dr Robert G. Robinson, OSH, Associate Director for Programme Development.

Centers for Disease Control and Prevention, Atlanta, Georgia, United States of America

LEGISLATION

THE THIRD WAVE OF TOBACCO LITIGATION IN THE US AND BEYOND

Holding tobacco companies liable for the harm caused by their products has long been one of the foremost goals of the tobacco control movement in the United States. If cases brought were successful, prices of tobacco products would increase to the point where nicotine addiction would become too expensive for young people. For the past 40 years, the tobacco industry has been able to hide information, misinform the public, and prevail in case after case while millions of their customers succumbed to the effects of their products.

Then, on 25 February 1994, David Kessler, MD, JD, Commissioner of the US Food and Drug Administration, sent a letter to the Coalition on Smoking OR Health informing the Coalition that the FDA had received "mounting evidence" that "the nicotine ingredient in cigarettes is a powerfully addictive agent" and that "cigarette vendors control the levels of nicotine to satisfy this addiction." He suggested that these conclusions, if established in an administrative or judicial proceeding, would justify regulating cigarettes as a drug, and ultimately banning tobacco products "containing nicotine at levels that cause or sustain addiction." Three days later, the television network ABC ran a story about how the cigarette companies manipulate nicotine levels. A tobacco company responded by suing ABC for libel, claiming that the programme cost the company $5 billion in lost revenue.

Under the leadership of California Congressman Henry Waxman, the health and environment subcommittee of the House Energy and Commerce Committee released damaging internal industry documents and held a series of hearings on nicotine manipulation. In March

1994, Commissioner Kessler testified that many modern cigarettes are "high-technology nicotine delivery systems." In April 1994, seven tobacco company chief executive officers testified *under oath* that nicotine is ***not*** addictive and that smoking has not been shown to cause cancer. Massachusetts Congressman Martin Meehan has asked US Attorney General Janet Reno to initiate a criminal probe of these tobacco executives based, in part, on their testimony and allegations of perjury.

Shortly after Congressman Waxman's subcommittee began its investigation, the most threatening development to the viability of the tobacco industry in the twentieth century – the ***Third Wave of Tobacco Litigation*** – began. On 29 March 1994, Wendell Gauthier, Ronald Motley, and other prominent plaintiffs' attorneys, filed a class action complaint in the United States District Court for the Eastern District of Louisiana against seven US cigarette manufacturers.

The proposed class representatives in *Castano v. The American Tobacco Company et al.*, are represented by a consortium of over 50 law firms from across the United States, and their action is based on Dr Keller's 25 March 1994, testimony in which he claimed that tobacco companies intentionally sell cigarettes containing an addictive level of nicotine. On 17 February 1995, Judge Okla Jones certified the nationwide class action suit for all nicotine-dependent or formerly nicotine-dependent persons and their estates. Soon, advertisements will begin to appear in major US newspapers to inform potential class members of their opportunity to join what promises to be the largest lawsuit in the history of the American legal system with, perhaps, close to one hundred million potential class members.

Two other class actions, in which the plaintiffs are being represented by Attorney Stanley Rosenblatt of Florida, have been certified by state courts there. In October 1994, a Florida state court judge in Miami granted the plaintiffs' motion for class certification in *Engle v. RJ Reynolds Tobacco Company et al.* The court certified and defined the class in *Engle* as "All United States citizens and

residents, and their survivors, who have suffered, presently suffer or who have died from diseases and medical conditions caused by their addiction to cigarettes that contain nicotine". On 21 December 1994, a Florida court granted the plaintiffs' motion for class certification in *Broin v. Philip Morris et al*. This class action is brought on behalf of airline flight attendants exposed to environmental tobacco smoke and could include up to sixty thousand class members.

While none of these cases guarantees a plaintiff's victory, ***class actions provide more of a level playing field and mean that the tobacco companies will not be able to pursue their usual strategy of forcing their opponents to spend exorbitant sums of money until they are forced to withdraw***. The attorneys in the *Castano* case, for example, have already raised over $6 million and purchased a large office building to serve as their litigation headquarters.

The Third Wave of tobacco litigation also includes a new kind of lawsuit that poses a grave threat to the US tobacco industry. On 23 May 1994, Mississippi Attorney General Mike Moore filed an unprecedented lawsuit to recoup Mississippi's share of the Medicaid costs necessitated by tobacco-induced diseases. The Medicaid programme pays for the health care costs for indigent Americans and draws from both state and federal funds. Moore founded Mississippi's claims on the fact that for four decades the tobacco industry has acted to "mislead and confuse the public about the true dangers associated with smoking cigarettes."

The Attorneys General in Minnesota and West Virginia followed Moore's lead by filing lawsuits seeking reimbursement for their respective state's healthcare costs due to tobacco use. Most recently, on 20 February 1995, the state of Florida filed its Medicaid reimbursement lawsuit against the tobacco industry seeking a reported $1.4 billion. Florida passed legislation last year that will make it easier for it to prevail in this lawsuit by eliminating certain tobacco industry defenses and allowing damages to be proven with statistical data. Massachusetts passed a similar law in 1994 and just announced its intention to enter the fray with yet another Medicaid reimbursement lawsuit. Other states are now scrambling to file their suits while there still is a solvent US tobacco industry to sue. While lawsuits against tobacco companies had been relatively rare over the past several years, now one must get in line to sue the industry.

The Third Wave is not limited just to the United States. On 13 January 1995, Donald Letourneau and other proposed class representatives opened a Canadian front in the battle to hold cigarette companies legally responsible for the illnesses they cause by filing a class action suit against three Canadian tobacco companies, in the General Division of the Ontario Court of Justice. The plaintiffs – all of whom began smoking when they were teenagers – state that they are representative of a class of persons who have all sustained damages such as emphysema, cancer, and the nicotine addiction itself, arising out of the conduct of the defendants.

And in the landmark decision opening a European front in the tobacco products liability battle, the Legal Aid Board for London granted limited legal aid certificates to two hundred claimants who wish to bring proceedings against cigarette manufacturers claiming damages for the harm they have suffered from smoking cigarettes. These certificates will enable the solicitors representing the claimants to receive government funding for their legal work on behalf of the claimants.

While the tobacco industry continues to rake in record profits selling products that could kill about 8%–9% of the world's population, these recent developments offer great hope. Even if governments are not willing to step in and take action to protect its citizens, those citizens can make the industry pay for the harm it has caused and, in the process, save the next generation from an all too familiar scenario of addiction, disease and death. If the past year's developments are any indication, the Third Wave of tobacco litigation promises to be a liability tidal wave that could wipe out the tobacco industry.

Richard A. Daynard, JD, PhD
Chairman of Tobacco Products Liability Project (TPLP)

Graham Kelder, JD, Managing Attorney of TPLP

Mark Gottlieb, JD, Staff Attorney of TPLP

COUNTRY PROFILES

MONITORING THE GLOBAL TOBACCO EPIDEMIC

In order to facilitate the global monitoring of the tobacco epidemic, WHO's Tobacco or Health programme (TOH), in close collaboration with the WHO regional offices, international agencies and regional experts, has been systematically gathering information over the last few years on a number of indicators of direct relevance to the tobacco or health situation in each of the Member States. This information will be published as a compilation of individual country profiles along with regional and global summaries.

Tobacco Alert is publishing a preview of selected country profiles in each of the next few issues, commencing this month with a view of the tobacco or health situation in Australia and Indonesia.

AUSTRALIA

Socio-demographic characteristics

Population	1990	1995	2025
Total	16,888,000	18,088,000	24,667,000
Adult (15+)	13,188,000	14,190,000	19,888,000
% Urban	84.3	86.0	91.6
% Rural	15.7	14.0	8.4

Health status

Life expectancy (1990-95) at birth: 74.7 (males); 80.6 (females)
at age 15: 59.8 (males); 66.2 (females)

Infant mortality rate in 1990-95: 7 per 1,000 livebirths

Age standardized death rate per 100,000 in 1990-92 from

	Ischaemic heart disease	*Cerebrovascular disease*	*Chronic Obstructive Pulmonary Disease*	*Lung cancer*	*All cancers*	*All causes*
Males	238.5	70.5	57.4	61.6	387.9	900.2
Females	129.1	64.7	22.4	19.0	248.9	550.1

Socio-economic situation

GNP per capita (US$), 1991: 17,120
GDP per capita (PPPS*), 1991: 16,680

Average distribution of labour force by sector, 1990-92: Agriculture 6%; Industry 24%; Services 70%

Adult literacy rate (%): Total 100; Male 100; Female 100

* PPPS = Purchasing Power Parity

Tobacco production, trade and industry

Agriculture

In 1990, 4,581 hectares were harvested for tobacco down from 5,422 in 1985. Less than 0.01% of all arable land is used for growing tobacco.

Production and trade

In 1990–92, about 12,610 tones of unmanufactured tobacco were produced or about 0.2% of the world total. Each year, Australia produces around 36,900 million cigarettes, accounting for about 0.6% of world production. Australia exports relatively little tobacco but imports of unmanufactured tobacco account for about 0.6% of all global imports. Australia earned about US$ 8.7 million in 1990 from tobacco exports, up from about US$ 5 million in 1985. Import costs of tobacco in 1990 amounted to US$ 55.4 million, or 0.1% of all imports costs.

Industry

About 3,000 people are engaged full time in the tobacco manufacturing industry. This is about 0.03% of the labour force.

Tobacco consumption

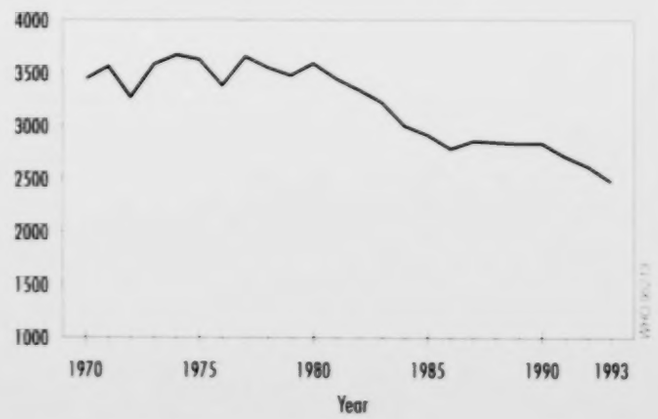
Almost all tobacco consumed in Australia is in the form of manufactured cigarettes. Hand-rolled cigarettes were estimated to be about 10% of manufactured cigarette consumption in the early 1970's, but since then this form of tobacco use has declined further. Per capita consumption peaked around 1975 at approximately 3,600 cigarettes per adult per year, and since then has fallen by almost 25%. In 1990, the average daily consumption of cigarettes among smokers was 22 for males and 19 for females.

Consumption of Manufactured Cigarettes

Annual average per adult (15+)

1970–72	3,410
1980–82	3,440
1990–92	2,710

Per Adult Consumption of Cigarettes (age 15+)



Tar/Nicotine/Filters

In 1990, tar levels of cigarettes ranged from 0.4 mg to 14.0 mg, and nicotine levels from 0.10 mg to 1.30 mg. Almost all (96%) of cigarettes sold are filter-tipped.

Relative cost of cigarettes

Data for the State of Victoria suggest that about 16 minutes of labour, at the average industrial wage, are required to purchase a packet of 20 cigarettes.

Prevalence

Overall prevalence has declined dramatically since the early 1980's. Currently, about 1 in 4 adult males smoke, and 1 in 5 females. As recently as 1964, almost 60% of males smoked as did 28% of females.

Tobacco use among population sub-groups

Data for 1990 indicate that smoking is lowest in professional/managerial workers (20%M;

% Cigarette Smokers Among Adults

	1970–72	*1980–82*	*1990–92*
Male	41.0	40.0	30.0
Female	29.0	31.0	27.0

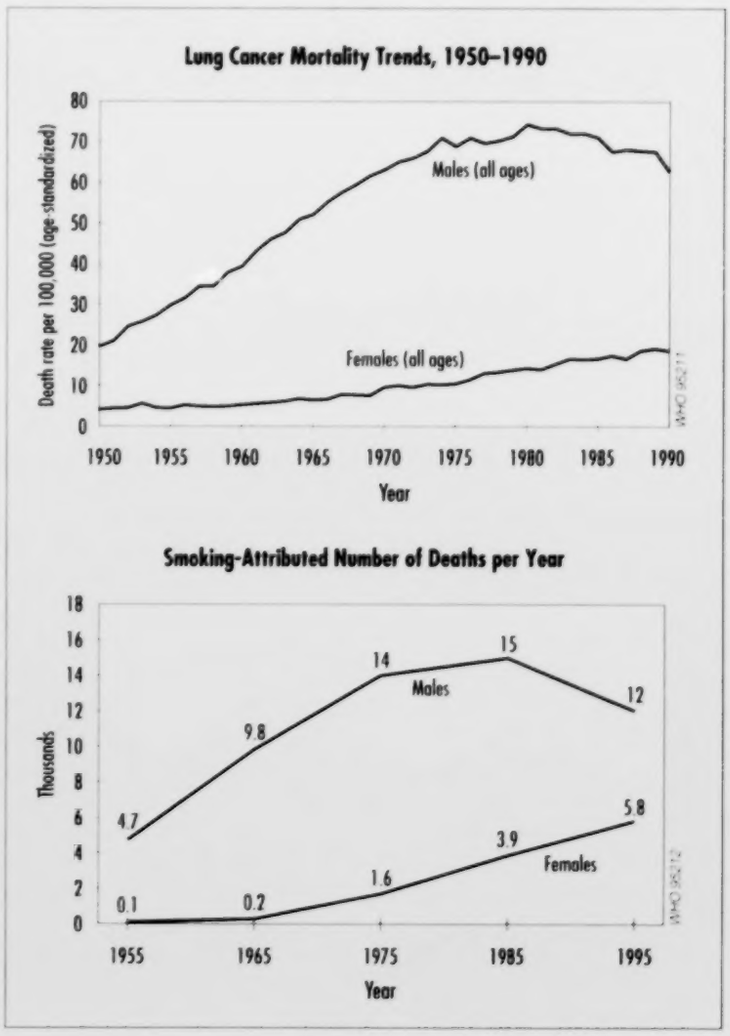
22%F), rising to 27% (M) and 26% (F) in clerical and sales workers, to 32% (M) and 28% (F) in skilled workers, and is highest in semi-skilled workers (43%M; 31%F). In 1975, 14% of physicians were current smokers, and 38% were ex-smokers.

Age patterns

According to a 1989 survey, the highest prevalence for both sexes occurs at ages 20–24 years (41% for males, 38% for females). Between 1980 and 1989, male prevalence at ages 20–24 declined from 56% to 41% whereas female prevalence has only changed slightly, from 40% to 38%.

Mortality from Tobacco Use

Between 1950 and 2000, it is estimated that tobacco will kill 675,000 Australians, or 13% of all deaths since 1950. The annual number of tobacco-attributable deaths among men is estimated to have peaked in 1985 and around 15,000 deaths but is still rising rapidly for women. During the 1990's, tobacco is projected to cause 12,000 male deaths each year, and just under 6,000 female deaths annually. 25% of all deaths among men in middle age (35–69) are due to tobacco, as are 15% of female deaths in this age group. 16% of all deaths in Australia in 1990 were due to tobacco use, and 25% of all cancer deaths. Lung cancer rates for men peaked around 1980 and are declining rapidly. Conversely, lung cancer mortality is rising rapidly among women.



Tobacco Control Measures

Control on tobacco products

Since 1993, a national ban on tobacco advertising has been in effect. Beginning in 1995, most sports sponsorships by tobacco companies will be banned. Since the fall of 1994, six rotating warnings (*Smoking is addictive; Smoking kills; Smoking causes heart disease; Smoking harms your baby; Your smoking can harm others; Smoking causes lung cancer*) are required on Australia cigarette packs. The warnings cover 25% of the front of the pack. Further health information covers one-third of the back and toxic substance information is on one side.

Most states ban the sale of cigarettes to those under eighteen, as well as prohibiting cigarettes from being sold in vending machines or in packs of less than 20 cigarettes. Smokeless tobacco is also banned in most states.

Cigarette taxes are moderately high – about 65% of the retail price. Most states operate Health Promotion Foundations that use part of state tobacco taxes to finance various health promotion and community development projects. Victoria was the first state to establish such a foundation, in 1987.

Protection for non-smokers

Smoking was banned in all workplaces of the federal government in 1988. Since then, protec-

tion from involuntary exposure to tobacco smoke has become widespread in both the public and private sectors. Successful legal actions by non-smoking employees and Australian smoking control advocacy groups have spurred employers to provide protection from involuntary exposure to tobacco smoke.

Smoking is banned in many public places and transit vehicles. All domestic flights are currently smoke-free, and as of July 1996, smoking will be banned on all international flights on Australian airlines.

Health education

Generous funding from tobacco tax-supported state Health Promotion Foundations means that Australia has some of the world's best smoking and health promotion and education programmes. The Victoria Health Promotion Foundation, for example, has a budget amounting to about AU$ 6.00 (approximately US$ 4.00) per capita. Money is used to replace tobacco sponsorship of sports and arts events by health promotion sponsorship. In addition, funding is extended to a variety of other cultural events that did not previously receive tobacco sponsorship.

INDONESIA

Socio-demographic characteristics

Population	1990	1995	2025
Total	182,812,000	197,588,000	275,598,000
Adult (15+)	117,578,000	132,398,000	212,324,000
% Urban	30.6	35.4	60.7
% Rural	69.4	64.6	39.3

Health status

Life expectancy (1990–95):

at birth: 61.0 (males), 64.5 (females)
at age: 15 52.3 (males), 55.1 (females)

Infant mortality rate in 1990–95: 58 per 1,000 livebirths

Socio-economic situation

GNP per capita (US$), 1991: 610, GDP per capita (PPP$*): 2,730

Average distribution of labour force by sector, 1990–92: Agriculture 56%; Industry 14%; Services 30%

Adult literacy rate (%): Total 84; Males 91; Females 77

* PPP$ = Purchasing Power Parity

Tobacco production, trade and industry

Agriculture

In 1990, 183,785 hectares were harvested for tobacco, down from 288,000 hectares in 1985. Between 1–2% of all arable land is used for growing tobacco.

Production and trade

Between 1990–1992, Indonesia produced approximately 2.0% of all unmanufactured tobacco in the world. In 1992, Indonesia produced about 161,000 million cigarettes (accounting for about 2.7% of world production), up from 83,900 in 1980. This growth in cigarette pro-

duction largely reflects the dramatic increase in machine-made kretek (clove/tobacco mix) cigarettes.

In 1992, Indonesia imported 21,650 tonnes of unmanufactured tobacco (about 1.4% of all global imports), while exporting 18,900 tonnes (about 1.1% of global exports). Indonesia imported 15 million cigarettes and exported 15,000 million cigarettes, or 2.2% of global exports.

In 1990, import costs of tobacco leaf and cigarettes amounted to US$ 42.1 million (0.1% of all import costs), compared with US$ 17 million in 1985. In 1990, Indonesia earned an estimated US$ 124.6 million from tobacco exports (0.4% of all exports earnings), up from approximately US$ 48.2 million in 1985.

Industry

About 214,300 workers were engaged full-time in the tobacco manufacturing industry in 1989.

Tobacco consumption

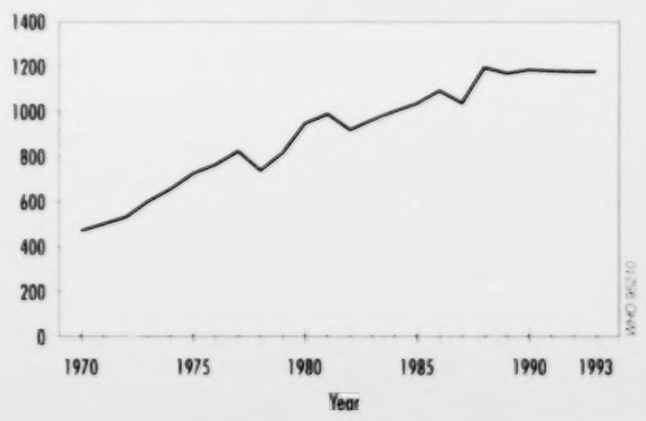
Most tobacco consumed in Indonesia is in the form of kretek cigarettes. Between 85–90% of all cigarettes smoked in Indonesia are kreteks. The cigarette market share of kreteks increased from about 30% in 1974 to about 90% in the 1990's. Since 1970–72, per adult consumption of cigarettes (all forms) has more than doubled, from 500 to 1190 per adult. A survey carried out in Jakarta in 1981 estimated that each smoker consumed 12 cigarettes a day, on average. About 5% of all smokers are estimated to smoke more than 20 cigarettes a day.

Tar/Nicotine/Filters

Tar levels are high. In 1983, the average tar content of 18 brands of kretek cigarettes was 58.0 mg. (range 41–71), while the average nicotine content was 2.4 mg. (range 1.2–3.2). These are substantially higher than levels permitted in industrialized countries. About 73% of manufactured cigarettes are filter tipped.

Consumption of Manufactured Cigarettes
Annual average per adult (15+)

1970–72	500
1980–82	950
1990–92	1,190



Prevalence

A 1980 national household survey found that about 54% of males 10 years of age and older, and about 3% of females, were regular (daily) smokers. A similar survey carried out in 1986 reported similar prevalence rates (53% of males, 4% of females). Other surveys carried out during the 1980's in Lombok, Jakarta and Yogyakarta have reported male prevalence levels of 75%, 65% and 61%, respectively, and female prevalence levels less than 5% (except for Jakarta: 9.8%). Nationally, prevalence is approximately 60% for men and 5% for women.

Tobacco use among population sub-groups

According to a 1985 survey in Semarang, 36% of doctors smoked, as did a surprising 79% of paramedical personnel. Almost all (96%) tricycle drivers in the survey smoked, as did over half (52%) of government civil servants. A 1992 survey of medical students revealed that 8% of males and 1% of females were daily smokers, while 39% of males and 15% of females were occasional smokers.

Age patterns

A 1985 survey of primary school children in Jakarta found that 49% of boys and 9% of girls aged 10–14 were daily smokers. However, a study in Jakarta in 1990 reported that only 1% of 11–14 year olds, 9% of 15 year olds, and 6% of 16 year olds were daily smokers, although the figures for occasional

smokers were 15%, 22%, and 44% respectively. The study also revealed that 9% started smoking when under 10 years old, 8 % at the age of 11, 18% at age 12, 23% at age 13, and 40% from ages 14–16. The vast majority (95%) smoked kreteks, and 72% reported that their parents did not know that they smoked.

Mortality from tobacco use

Nationally reliable mortality and morbidity data are not available. However, whenever comparable data are available, they point to an increase in the major chronic diseases associated with smoking. Estimates suggest that tobacco-attributable mortality has risen from 2–3% of all deaths in 1980 to 3–4% in 1986. This would suggest that about 57,000 deaths a year (primarily males) are already attributable to tobacco use, and this number can be expected to increase dramatically within the next few decades.

Tobacco Control Measures

Tobacco control measures

Most tobacco control measures have been organized by non-governmental organizations (NGOs).

Control on tobacco products

The only restrictions on tobacco advertising on television are that no person can be shown smoking and no cigarette can be shown. There are no restrictions for tobacco promotion on radio, billboards, point of sale, print media, or sponsorship. Health warnings on cigarette packets were introduced in 1991. There are no bans on vending machine sales or on sales to minors.

Tax changes in 1991 increased the price of cigarettes by an average of 30%. In 1992, there was a 37.5% tax on local brands and a 70% tax on imports. Tobacco tax comprises 10% of total tax revenue.

Protection for non-smokers

Three government ministries are officially smoke-free, but this is often not enforced. By regulation, all health facilities are smoke-free, although some doctors even smoke in front of their patients. Schools up to the university level are smoke-free. Most air-conditioned cinemas have regulations prohibiting smoking, and some restaurants have voluntary bans. Flights of less than two hours are smoke-free, but there are no laws or regulations regarding smoking on trains, buses or in taxis.

Health education

NGOs, such as the Indonesian Cancer Foundation and the Indonesia Heart Foundation have produced posters, pamphlets and leaflets, and some offer smoking cessation classes. The NGOs also organize many community events, and World No-Tobacco Day is regularly celebrated in Indonesia. However, tobacco control activities appear to be limited, and there is no comprehensive national tobacco strategy.

NEWS BRIEF

SENEGAL

On 6 December 1992, the Senegal Anti-Tobacco Movement (MAT-SENEGAL) was founded in Dakar, Senegal, with the aim of providing better health protection for Senegalese people. MAT-SENEGAL is made up of young students under the authority of an advisory board of health specialists and academics (physicians, teachers and students).

The aims of MAT-SENEGAL are:

- to increase public awareness of the harmful consequences of tobacco consumption;
- to protect non-smokers from the health risks of passive smoking; and
- to reduce tobacco consumption at the same time as increasing public awareness of the dangers of tobacco consumption to smokers, their families and the general public.

MAT-SENEGAL is now well-known both nationally and internationally thanks to measures it has taken in Senegal which have produced significant results:

- the drawing up and implementation of the Tobacco and Health programme – "choice for young people" – which involves promoting young people's awareness of these issues in 54 secondary schools in Dakar, as well as at the National Police College;
- the establishment of Anti-Smoking Clubs in 30 secondary schools in Dakar;
- the display of anti-smoking stickers in pharmacies in Dakar and Thies;
- regular contact with numerous sporting associations;
- the organization of conferences with the participation of Anti-Smoking Clubs;
- a five-day plan to help smokers stop, with large numbers of smokers giving up;
- the participation of MAT-SENEGAL in the local fair;
- the setting up of a forum of young people who support World No-Tobacco Day;
- active participation at the Conference of African Anti-Tobacco Movements which was held in Accra, Ghana, 28–30 June 1994;
- significant participation of MAT-SENEGAL at the Ninth World Conference on Tobacco and Health, 10–14 October 1994, Paris.